“What Goes Where”: A Guide to Clinical Documentation at Western Health.

Sunshine Secure GEM

iPM:	EMR (Cerner):	Paper:	BOSSnet:	Other Applications:
• Patient registration • Updating patient demographic information/ compensable • Print patient labels • Admit/Discharge/Transfer patients • iPM Admission/Discharge Form • Presence of an advance care plan – Legal Alert • Presence of a substitute decision maker – Legal Alert • FIM reporting • Barthels reporting	• Patient ID wristband • Allergies • Alerts • Place Diet order • Inpatient clinical documentation • ISBAR Handover • Documentation of lines and devices • Allied Health/Care Coordination Referrals • Medication Orders/Administration • Intravenous & subcutaneous infusion orders/administration • Pathology Orders, Collections/Results • Radiology Orders/Reports • Discharge Planning/Case Conference Documentation (incl GAP form) • Discharge Prescription • Discharge Summaries • Red Dome order • MMSE – results documented in MO note • CNC referrals • Infectious Diseases Screening Tool	• Consent Form (AD34) • Passport To Surgery (AD250) • Blood Transfusion Records/Consent (AD283.1) • Group and Hold forms • Respond Blue Record AD299 • Electrocardiogram (ECG) • Enteral Nutritional Plan WHAH389.2 • Acute Resuscitation Plan (ARP) ALERT 3 *trial form • FIM form • Barthel form • Subacute Admission Information form (AD 23.1) • Subacute Discharge Information form (AD 23.2) • FAB & RUDAS • MMSE– patient required to draw on assessment • Wound Care Chart (Post-Acute Care referrals on discharge) • Restraints documentation.	• Outpatient Clinic Referrals • Outpatient Documentation • Non Synapse and Non Dorevitch results • Community Services Referrals (CAU) – with paper drug chart and wound chart as required. *All internal and external paper documentation will continue to be scanned as per pre EMR process.	• Synapse • Patient Journey Board/Miya • CBORD Diet Management System